Maryland Comprehensive Primary Care Model
Primary Care Council

Department of Health and Mental Hygiene
November 15, 2016

Goals of Primary Care Model

- **Improve the health of Maryland through:**
  - Person-centric healthcare
  - Team-based support
  - Evidence-based approach
  - Consistent quality and outcome metrics
  - Volume to Value
  - Reduce potentially avoidable utilization
  - Improve management of chronic illness
  - Alignment with Maryland All-Payer Model and Medicaid Duals ACO
  - Alignment with State Population Health Improvement Plan (due to CMMI: 12/31/2016)

- **Timeline:**
  - 12/31/2016: Submit Primary Care Model concept paper to CMMI
  - 2017: Enhanced Infrastructure development begins:
    - Coordinating Entity development
    - Regional Care Management Entity formation / applications
    - Practice adoption/technical assistance
    - HIE Expansion, more primary care providers achieve connectivity
  - 2019 – 2023: Sustainability achieved through long term Return on Investment

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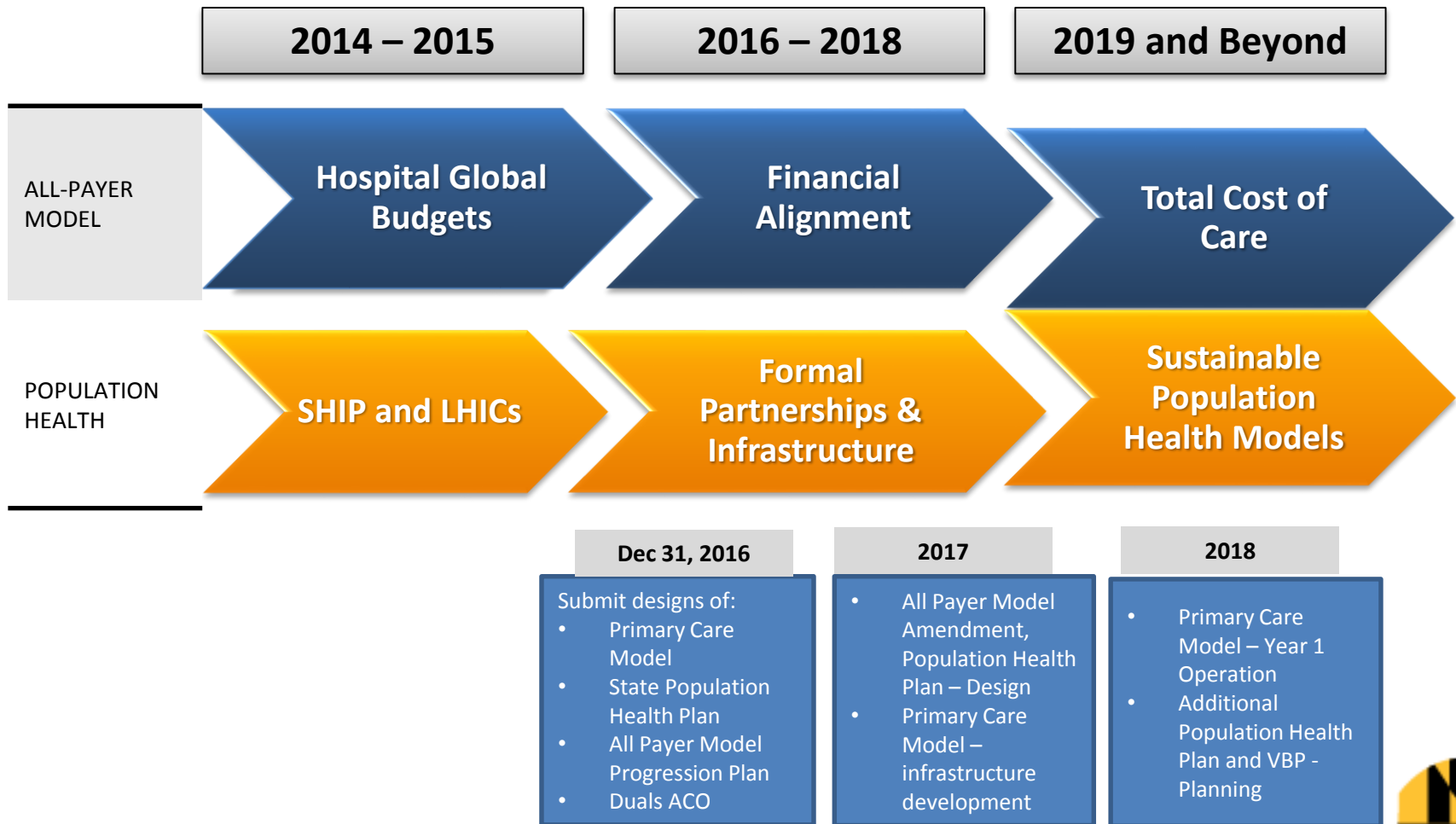DEPARTMENT OF HEALTH
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How the Primary Care Model Can Help Providers

- Provides funding for care managers to be embedded in primary care practices; alternative is deployment of care managers to practices on as-needed basis

- Funding for deployment of pharmacists, nutritionists, social workers, community health workers and others as needed

- Assistance with CRISP connectivity

- Assistance with medication management, care transitions

- Help with open access scheduling, telehealth, e-visits, group visits

- Funding for non-visit activities vital to good health

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Transformation Progression

	2014 – 2015	2016 – 2018	2019 and Beyond
ALL-PAYER MODEL	Hospital Global Budgets	Financial Alignment	Total Cost of Care
POPULATION HEALTH	SHIP and LHICs	Formal Partnerships & Infrastructure	Sustainable Population Health Models

Dec 31, 2016

Submit designs of:
- Primary Care Model
- State Population Health Plan
- All Payer Model Progression Plan
- Duals ACO

2017

- All Payer Model Amendment, Population Health Plan – Design
- Primary Care Model – infrastructure development

2018

- Primary Care Model – Year 1 Operation
- Additional Population Health Plan and VBP - Planning

Relationship to All-Payer Model and Progression Plan

- The Primary Care Model will help sustain the early gains of the All-Payer Model as targets becoming increasingly reliant on factors beyond the hospital

  – Aligns incentives; important to design in a way that ensures hospitals are not responsible for risks they cannot control

- Complements the Care Redesign Amendment

  – Community-level alignment to CCIP

- Reduces avoidable hospitalizations and ED usage through advanced primary care access and prevention

  – Components include embedded care managers, 24/7 access to advice, medication mgt., open-access scheduling, behavioral health integration, and social services

- Enhanced version of CPC+ will complement and support hospital global budgets

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Relationship with CCIP

- Align community providers with Hospital Model goals:
  - *Ideal: CTO coordinates between hospital-identified patients and PCHs*
- Direct delivery of services in the community
  - Non-office based primary care
  - Align with HSCRC
    - Provide community based care coordination and population health
- Differs in *Risk Stratification*
  - PCHs must risk stratify their own population, identifying high-risk patients needing:
    - Longitudinal, relationship-based care management
    - Short-term, episodic care management (not depending on risk status)
  - CTOs will support practice management for identified populations
  - CEs will risk stratify to determine care management fee for each PCH

PRIMARY CARE TODAY

Current Status of Practicing Providers

2. Which best describes how you feel about the future of the medical profession?	MD	National
Very positive/optimistic	6.7%	6.8%
Somewhat positive/optimistic	26.3%	30.4%
Somewhat negative/pessimistic	47.1%	41.4%
Very negative/pessimistic	19.9%	21.4%

14. How familiar are you with the Medicare Accountability and CHIP Reauthorization Act (MACRA)?	MD	National
Very unfamiliar	35.7%	33.4%
Somewhat unfamiliar	22.1%	22.9%
Neither familiar nor unfamiliar	24.8%	23.8%
Somewhat familiar	14.4%	14.0%
Very familiar	3.0%	5.9%

21. Which of the following best describes your current practice?	MD	National
I am overextended and overworked	32.5%	28.2%
I am at full capacity	46.7%	52.4%
I have time to see more patients and assume more duties	20.8%	19.4%

MACRA

Law *intended* to align physician payment with *value*

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
Quality Payment Program

Merit-Based Incentive Payment System (MIPS)

Alternative Payment Models (APMs)

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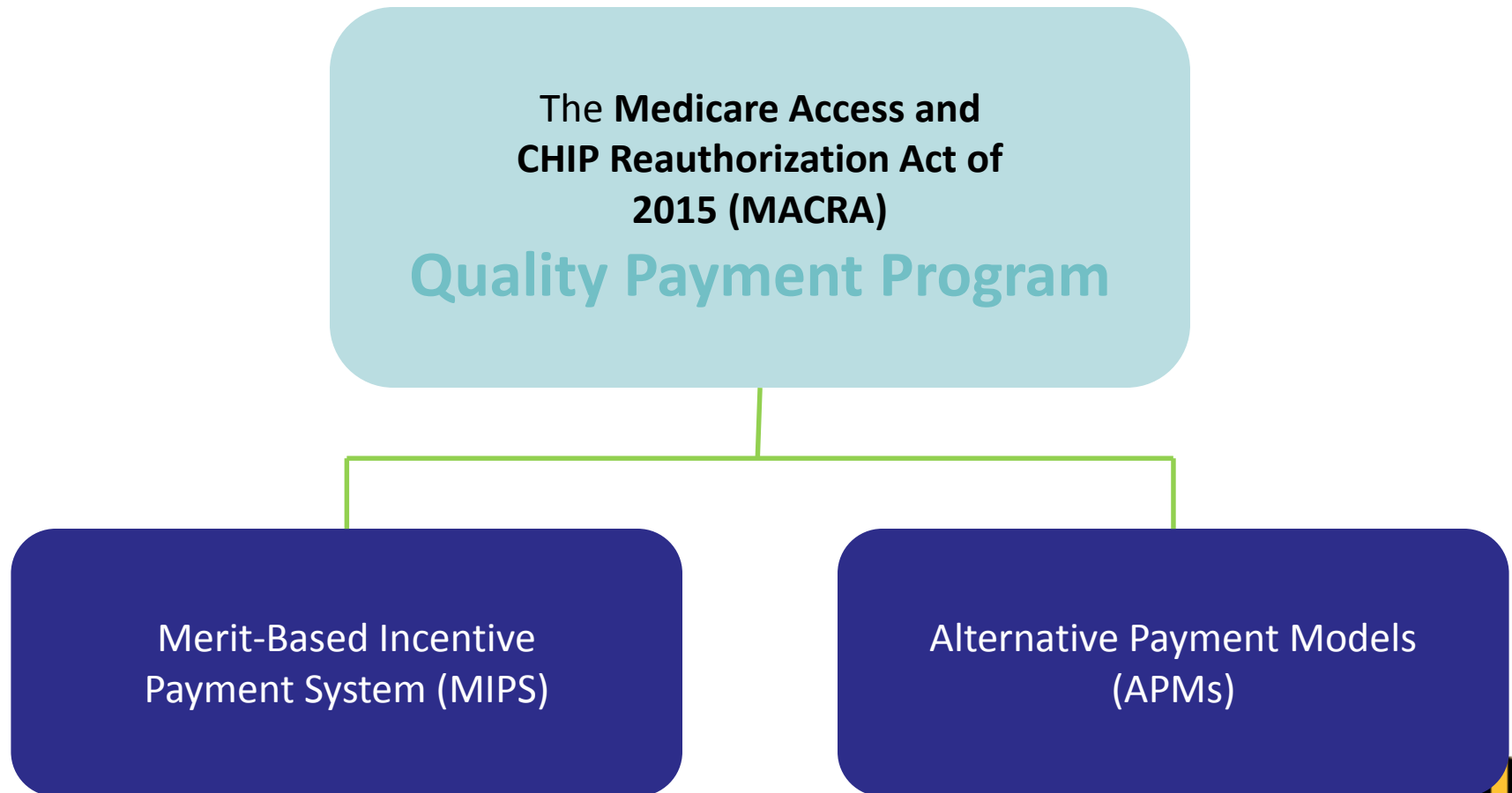
The Quality Payment Program Provides Additional Rewards for Participating in APMs

Potential financial rewards

Not in APM

MIPS adjustments

In APM

MIPS adjustments

+

APM-specific rewards

In Advanced APM (AAPM)

APM-specific rewards

+

5% lump sum bonus

If you are a
Qualifying APM Participant (QP)

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Leveraging Window of Opportunity

- CMMI willing to allow the State to customize CPC+, which is an approved AAPM model

- Maintaining All Payer Model and broader health transformation in State depend on primary care with strong supports
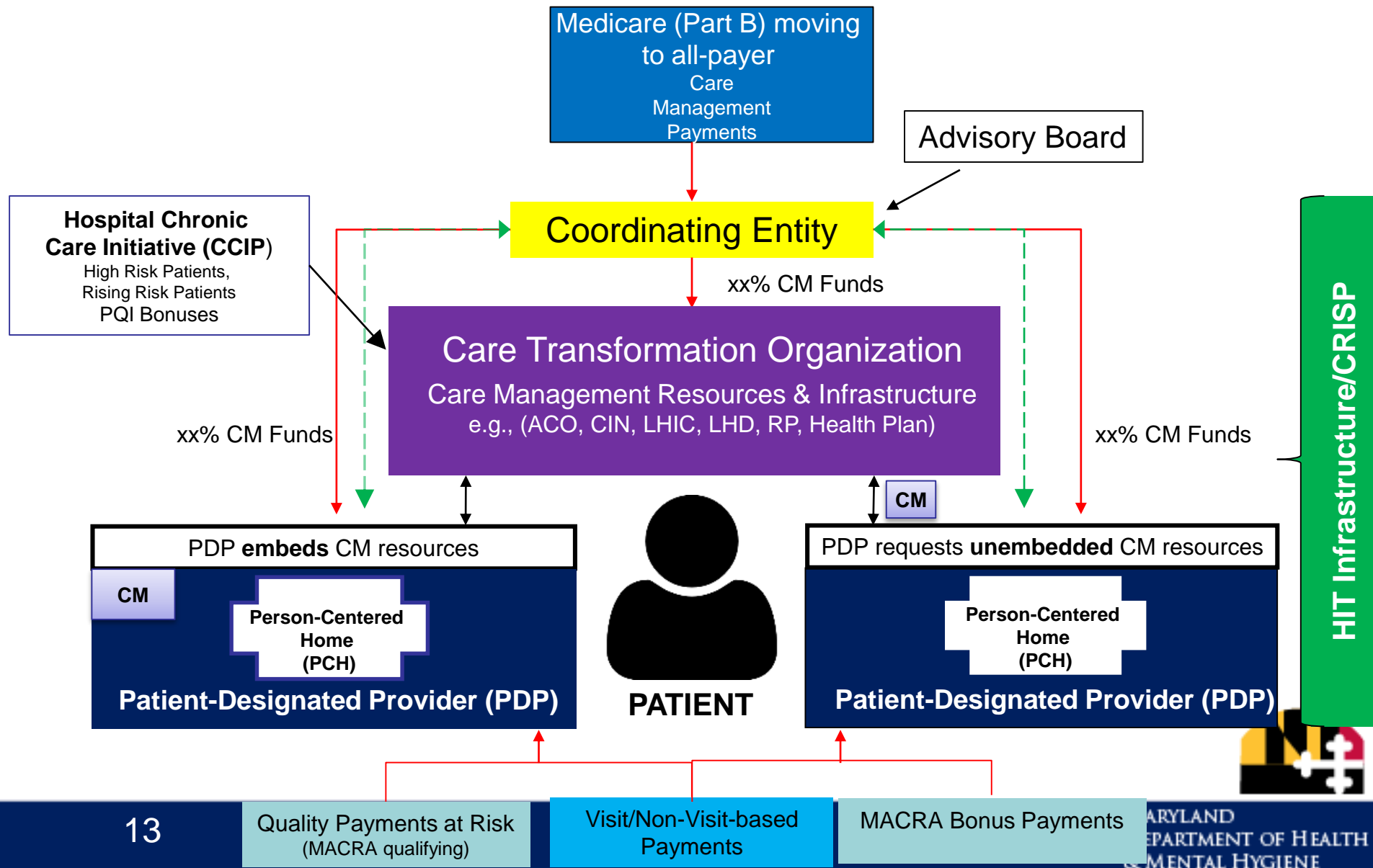
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OVERVIEW OF PRIMARY CARE MODEL

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Maryland Primary Care Model

Medicare (Part B) moving to all-payer
Care Management Payments

Advisory Board

Hospital Chronic Care Initiative (CCIP)
High Risk Patients, Rising Risk Patients
PQI Bonuses

Coordinating Entity

xx% CM Funds

Care Transformation Organization
Care Management Resources & Infrastructure
e.g., (ACO, CIN, LHIC, LHD, RP, Health Plan)

xx% CM Funds

xx% CM Funds

CM

PDP embeds CM resources

PDP requests unembedded CM resources

CM

Person-Centered Home (PCH)

Person-Centered Home (PCH)

Patient-Designated Provider (PDP)

PATIENT

Patient-Designated Provider (PDP)

HIT Infrastructure/CRISP

Quality Payments at Risk
(MACRA qualifying)

Visit/Non-Visit-based Payments

MACRA Bonus Payments

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Dollar Flow and Contracting

CM Dollar Flows

- CTOs will have a *prescribed* amount of the % dollars
    - This is determined by the CE, with stakeholder input
- Dollars will be *capped* based on suite of services offered
- Practices will receive *bonus* dollars

Contracting

- Providers/Practices can contract directly with the Coordinating Entity (CE)
- More flexibility in the model
- Providers/Practices will have to meet all the care transformation requirements and services
    - Set by the Governing Body
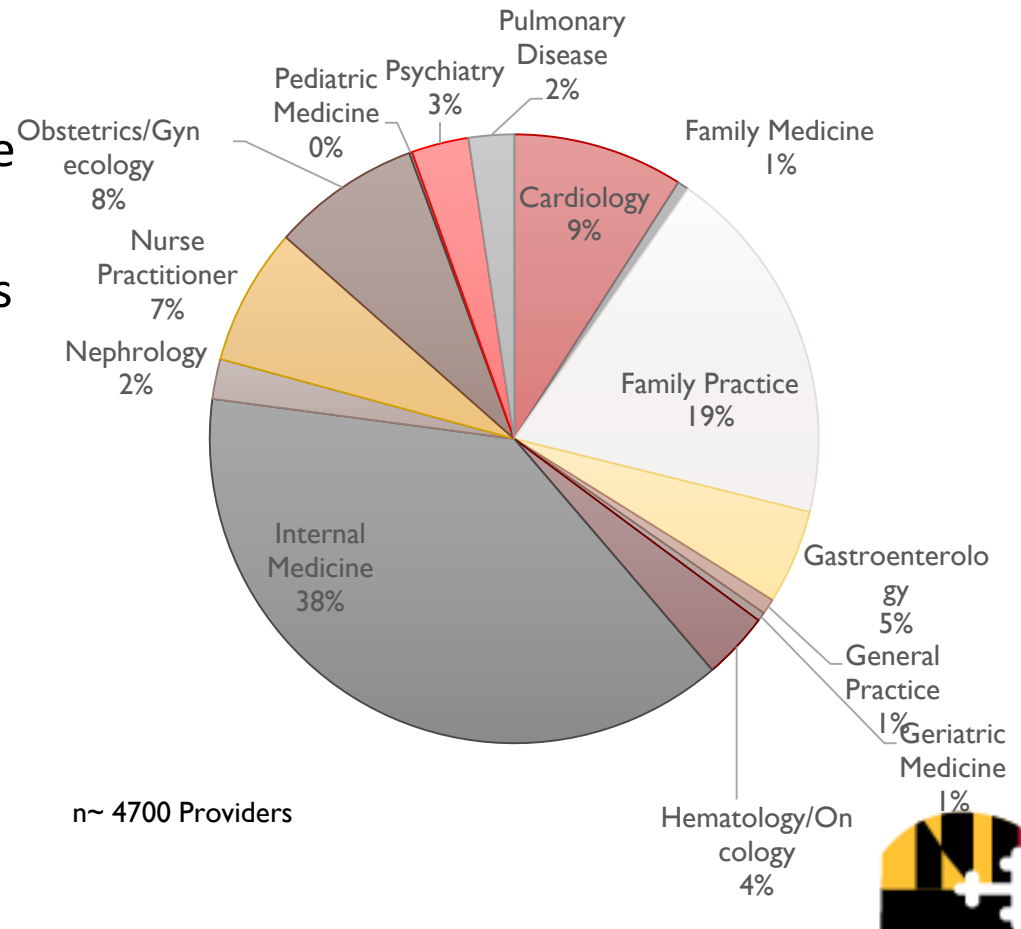- If practices are able to do this they will *not* have to contract with a CTO

PATIENT DESIGNATED PROVIDERS

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PDPs

- Patient Designated Providers (PDPs)
  - The most appropriate provider to manage the care of each patient
  - Provides preventive services
  - Coordinates care across the care continuum
  - Ensures enhanced access
  - Most often this is a PCP but may also be a specialist, behavioral health provider, or other depending on patients health needs

Percentage of Patient-Designated Providers by Specialty

Obstetrics/Gynecology 8%
Pediatric Medicine 0%
Psychiatry 3%
Pulmonary Disease 2%
Family Medicine 1%
Cardiology 9%
Nurse Practitioner 7%
Nephrology 2%
Internal Medicine 38%
Family Practice 19%
Gastroenterology 5%
General Practice 1%
Geriatric Medicine 1%
Hematology/Oncology 4%

n~ 4700 Providers

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Person Centered Home

- Person-Centered Home (PCH)
  - An individual provider or group of providers that deliver care as a team to a panel of patients
  - The PCH must have at least one PDP
  - PCH practices must meet the requirements laid out by the Model – CPC+ like
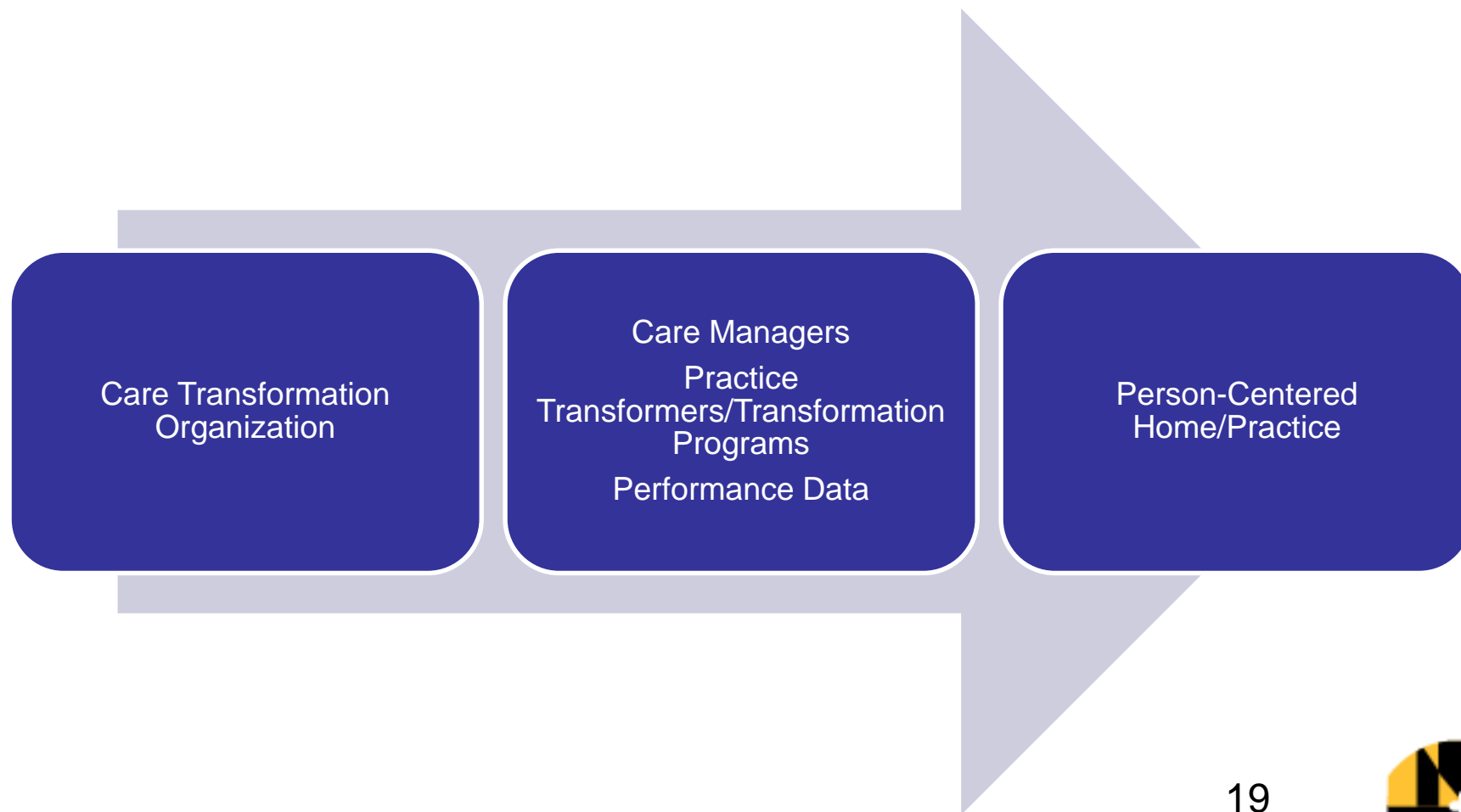 - Practices may span multiple physical sites in the community

Practice Transformation is Key

- Practices will **NOT** be expected to be transformed on day 1 or program start

- The State is committed to designing a system to provide assistance with practice transformation:
  - Care Transformation Organizations (CTOs) will be approved to assist practices
  - Practices will choose the best CTO for them
  - Practices may elect to <u>not</u> choose a CTO and contract directly with CE; practices need to provide evidence of sufficient infrastructure to meet requirements of PCM to contract with CE directly
  - CTOs will ensure that practices meet requirements under program by developing high functioning services including:
    - Care management resources and people
    - Technical assistance on practice transformation
    - IT supports (CTO and CRISP)

Driving Practice Transformation

Care Transformation Organization

Care Managers

Practice Transformers/Transformation Programs

Performance Data

Person-Centered Home/Practice

19

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The Role of Care Managers

- Care managers will work very closely with physicians, NPs, PAs, nurses and other members of a primary care team
- They will assist the clinicians, patients, and family members in the development and implementation of care plans tailored to each patient's needs
- Care managers will arrange for services such as transportation, nutrition, and help smooth transitions of care
- Care managers can be embedded in PDP practices; an alternative approach for the deployment of care managers to practices on an as-needed basis.

Who is a Care Manager?

- An RN/LPN or MA in most circumstances (Level 1)

- LCSW or CHW with special training – additional resources wrapped around as needed (Level 2)

- An individual with knowledge of community resources to address non-medical needs: e.g. transportation, DME, eligibility for programs, home safety issues, behavioral health needs

- A team member whose efforts are integrated with pharmacists, therapists, specialists and primary care.

- A trusted advocate who shares important data via CRISP in order to keep patients safe as they navigate across settings of care and different health systems

21

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I am a Patient: What does a transformed practice look like to me?

- I am a Medicare beneficiary

- Provider selection by my historical preference

- I have a team caring for me led by my Doctor

- My practice has expanded office hours

- I can take advantage of open access and flexible scheduling:
  - Telemedicine, group visits, home visits

- My care team knows me and speaks my language

- My records are available to all of my providers

- I get alerts from care team for important issues

- My Care Managers help smooth transitions of care

- I get Medication support and as much information as I need

- I can get community and social support linkages (e.g., transportation, safe housing)

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I am a Provider: What does a transformed practice look like to me?

- Voluntary participation

- Able to spend more time with patients

- Patient care management support based on severity index

- Care managers embedded in my practice and part of my care team

- Practice incentives:

  – 5% MACRA participation bonus (lump sum); CPC+ participation

  – Quality and Utilization incentive bonus $2.50 or $4 PBPM (Track 1, Track 2, respectively) – Prepaid

  – Track 2 comprehensive payment – Prepaid

  – Care Management payment PBPM risk adjusted

  – Care management infrastructure

  – Practice transformation support

  – Healthier patient population

  – Reimbursement for non-office based visits

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CARE TRANSFORMATION ORGANIZATIONS

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How do I become a Care Transformation Organization?

- Certification by external accrediting body

- Bi-directional accountability CTO <--> Practice / Providers

- CTOs cannot apply on behalf of Practices / Providers

- CTOs are non-regionally based

- CTO internal competition

- Apply through Coordinating Entity (CE)

  - CE holds CTO accountable for requirements and outcomes

- Market Share Assessment: On-going

  - Subcontracts: Coordinating Centers, Local Health Departments, HCAM

- Ability to provide following services includes:

  - Care management infrastructure

    - Nurses, pharmacists, nutritionists, Community Health Workers, LCSWs, Health educators

  - Technical assistance for 24/7 after-hours access

  - Social support connections – Community Health Workers

  - "Hot-spotting" areas with high and/or specific needs

  - Pharmacist support for medication management and consultations

  - Assisting practices in meeting Primary Care Model requirements

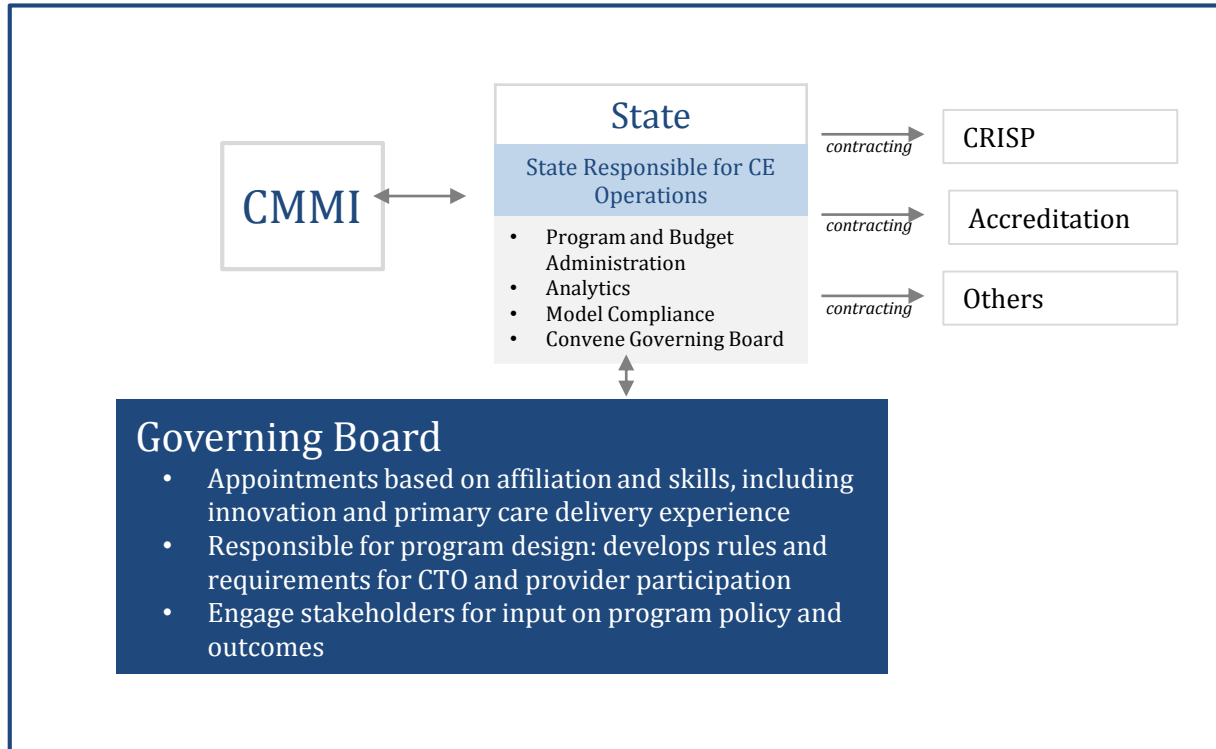 - Physician training resources

  - CRISP connectivity

COORDINATING ENTITY

Coordinating Entity Organization

Coordinating Entity Organization Design

CMMI

State

State Responsible for CE Operations

- Program and Budget Administration
- Analytics
- Model Compliance
- Convene Governing Board

contracting → CRISP

contracting → Accreditation

contracting → Others

Governing Board
- Appointments based on affiliation and skills, including innovation and primary care delivery experience
- Responsible for program design: develops rules and requirements for CTO and provider participation
- Engage stakeholders for input on program policy and outcomes

Functions of Coordinating Entity

| Functions of the CE |
|---|
| **Program Design** |
| Develop requirements for CTO and PCH participation |
| Engage stakeholders through an Advisory Board for input on program policy and outcomes |
| **Program and Budget Administration** |
| Design, review and approve CTO and PCH applications |
| Administer Medicare beneficiary attribution to PCHs |
| Run algorithms for the defined payment logic to determine distribution of care management fees |
| Financial administration (accepting the dollars from CMS or another payer and redistributing across system) |
| Enter into and monitor contracts with key partners, such as:
         • External National Accreditation Organization for CTO certification
         • Other partners
     Develop boilerplate contracts for relationship between CTOs and PCHs |
| **Informatics/Data Analytics** |
| Perform ongoing reporting and analysis in support of model-specific goals (in support of Learning System) |
| Provide CTOs and PCHs with regular reports to inform decision-making (in support of Learning System) |
| Provide regional population health outcomes/metrics |
| **Model Compliance** |
| Monitor CTO and PCH performance for assessment of compliance with model participation |
| Recommends corrective action plans where needed |
| **Model Evaluation (tentative)** |
| Contract with an independent outcome evaluation group to monitor performance against goals of population health, quality of care, and cost targets |

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Summary View of Primary Care Program
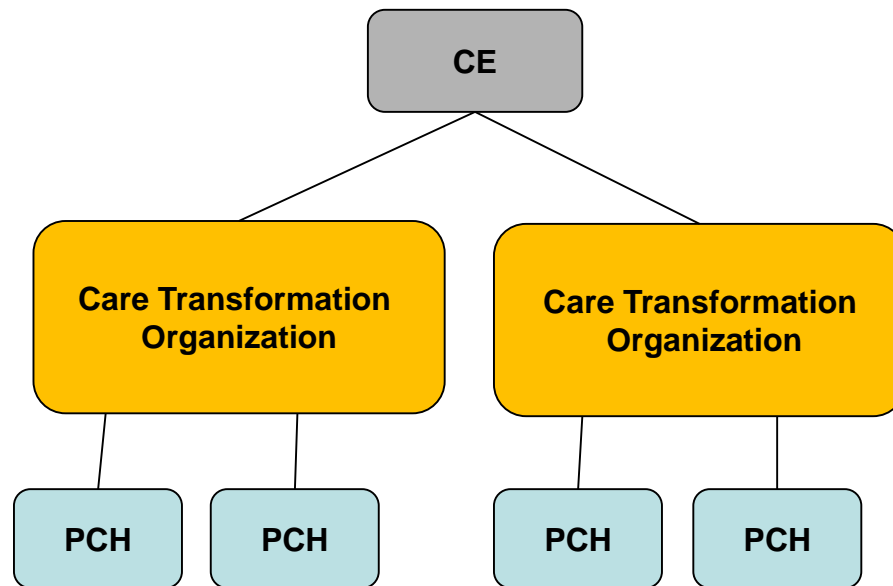
FURTHER MODEL DEVELOPMENT

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Stakeholder Engagement

- Ongoing meetings with:

  - Providers

  - Health Systems

  - Payers

  - Consumers

  - Local Health Departments

- CMMI meetings on a biweekly basis

- HSCRC, Medicaid, CRISP, MHCC collaboration

- Incorporating Dual Eligibles FFS outside of ACO regions – working with Duals Workgroup

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Concept Paper

- Finalized Concept Paper (November 14)

- Draft to be shared informally with CMMI (November 16)

- **Release Concept Paper for public comment (November 30)**

- Submit Concept Paper by December 31, 2016

- Formal proposal to be developed in early 2017

- Track our progress:

google us "DHMH OPHI Healthcare Transformation"

http://pophealth.dhmh.maryland.gov/Pages/transformation.aspx

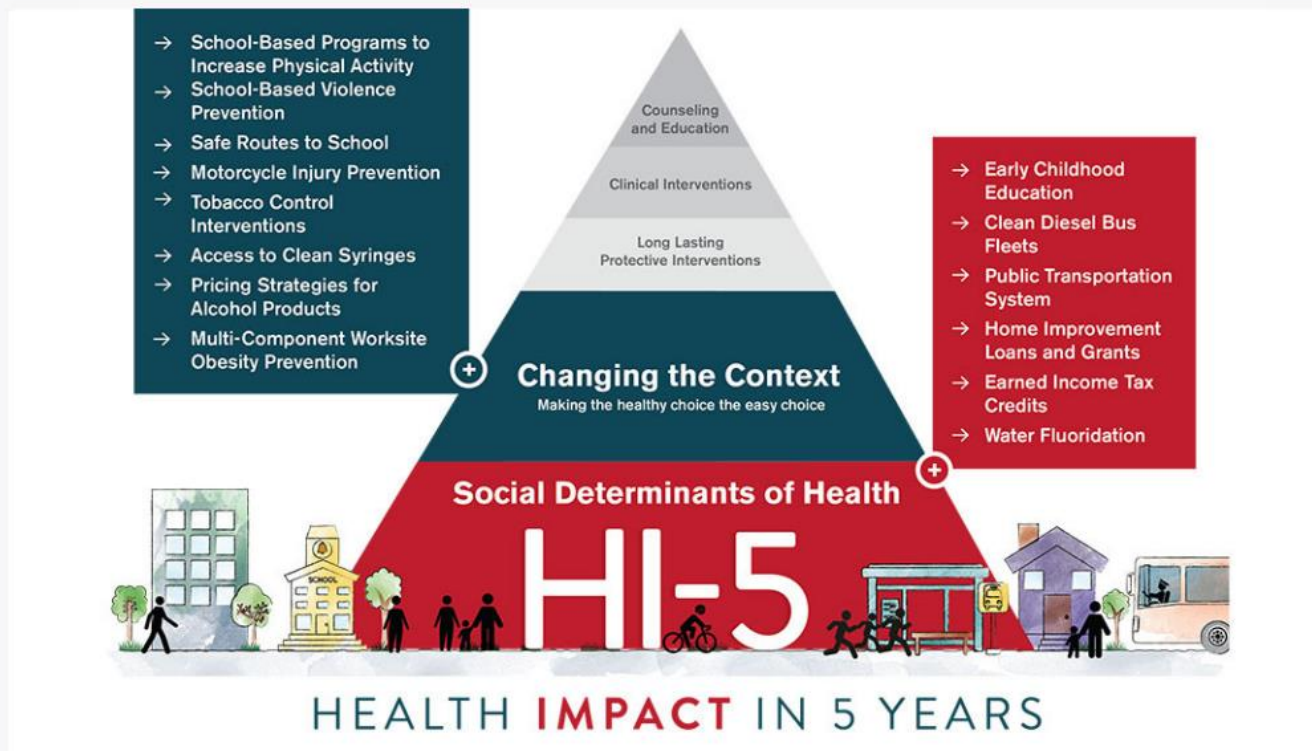MARYLAND
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The Importance of Population Health to the All-Payer Model

Figure 4 | Health Impact in 5 Years

Source: U.S. Centers for Disease Control and Prevention, Health Impact in Five Years. http://www.cdc.gov/hi5

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